Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth

MassHealth
All Provider Bulletin 294
May 2020

TO: All Providers Participating in MassHealth

FROM: Amanda Cassel Kraft, Acting Medicaid Director

RE: MassHealth Coverage Flexibilities for Services Related to Coronavirus Disease 2019

Background

MassHealth's mission is to improve the health outcomes of our diverse members and their families by providing access to integrated health care services that sustainably and equitably promote health, well-being, independence, and quality of life. In support of that mission, MassHealth provides broad coverage of medically necessary health care services to its members. In light of the state of emergency declared in the Commonwealth due to the 2019 novel Coronavirus (COVID-19) outbreak, MassHealth is introducing additional guidance to all providers.

This bulletin supplements *All Provider Bulletin 289* and *All Provider Bulletin 291* by providing guidance for providers regarding additional flexibilities, including flexibilities related to billing for services rendered via telehealth, billing for services rendered to dual-eligible members via audio-only telehealth, coverage and billing for remote patient monitoring, the extension of certain informational edits, and billing for preventive visits for children and adults. Unless specifically noted in this bulletin, providers should comply in all respects with *All Provider Bulletin 289* and *All Provider Bulletin 291,* which remain in full force and effect.

This bulletin applies to members enrolled in MassHealth fee-for-service, the Primary Care Clinician (PCC) Plan, or a Primary Care Accountable Care Organization (ACO). Information about coverage through MassHealth Managed Care Entities is included in applicable MCE Bulletins.

The Massachusetts Executive Office of Health and Human Services (EOHHS) is coordinating with federal and local partners to respond to COVID-19. As this situation evolves, EOHHS may issue additional guidance on this topic as informed and directed by the Massachusetts Department of Public Health (DPH) and the federal Centers for Disease Control and Prevention (CDC).

As with *All Provider Bulletin 289* and *All Provider Bulletin 291*, this bulletin, and the flexibilities described herein, shall remain effective for the duration of the state of emergency declared via Executive Order No. 591. Upon the expiration of that state of emergency, MassHealth will evaluate the continued need for each of the flexibilities that follow, and make appropriate adjustments, as necessary.

Additional Billing Flexibility Applicable to All Providers Rendering MassHealth-Covered Services via Telehealth

As explained in All Provider Bulletins 289 and 291, MassHealth is temporarily permitting MassHealth providers to deliver all clinically appropriate, medically necessary MassHealth-covered services to MassHealth members via telehealth (whether audio-only or live video) in accordance with the standards set forth in those bulletins. Since publishing those bulletins, MassHealth has learned that, in certain instances, providers have struggled to identify the appropriate code to describe a service rendered via telehealth because certain codes contain references to specific telehealth modalities (e.g., services rendered telephonically) while other codes that might otherwise more accurately describe the service rendered are silent on the means of service delivery or require face-to-face delivery.

To facilitate the implementation of the telehealth-related flexibilities announced in All Provider Bulletins 289 and 291, for the duration of the state of emergency declared via Executive Order. No 591, and notwithstanding any MassHealth requirement to the contrary, MassHealth will permit providers submitting claims to MassHealth for services delivered via telehealth in accordance with those bulletins to disregard any references within a service code description to the means by which a service is delivered (e.g., in-person, through live-video telehealth, or via telephone) when identifying the appropriate service code.

Providers must ensure that, in all other respects, they select the service code that most accurately describes the service rendered. This flexibility notwithstanding, providers must comply in all respects with all other applicable laws, regulations, and subregulatory guidance.

Services Delivered to Individuals Enrolled in MassHealth Fee-for-Service and Eligible for Medicare (Dually Eligible Members) via Audio-Only Telehealth

As explained above, and as noted in All Provider Bulletins 289 and 291, MassHealth is temporarily permitting MassHealth providers to render all clinically appropriate, medically necessary MassHealth-covered services through telehealth, either through live video or through audio-only (telephone) communication, in accordance with the standards set forth in those bulletins. In contrast, Medicare's coverage of services rendered via audio-only telehealth is limited to certain services. Providers should reference the latest CMS guidance for Medicare coverage of audio-only telehealth services prior to billing MassHealth.

To facilitate the implementation of MassHealth's temporarily broadened telehealth policy, and notwithstanding 130 CMR 450.316, effective for dates of service on or after March 12, 2020, MassHealth will permit providers to submit directly to MassHealth, without prior submission to Medicare, claims for clinically appropriate and medically necessary services rendered to dually eligible members via audio-only telehealth that are not coverable by Medicare. Providers invoking this policy must comply in all respects with this bulletin and all other applicable laws, regulations, and subregulatory guidance.

As explained above, this flexibility applies only to services rendered to dually eligible members via audio-only telehealth that are not coverable by Medicare. As a result, providers delivering services to dually eligible members via a telehealth modality that includes a live video component must first submit those claims to Medicare for adjudication. Similarly, providers rendering services that are

coverable by Medicare when rendered via audio-only telephone communication to dually eligible members must submit those claims to Medicare for adjudication. By submitting directly to MassHealth a claim for a service rendered to a dually eligible member via audio-only telehealth, the billing provider is certifying to MassHealth that the service was not coverable by Medicare as of the date of service. MassHealth will pursue as overpayments all payments to providers for services billed directly to MassHealth that were coverable by Medicare.

The following two subsections provide billing instructions for 837P Transactions and Direct Data Entry for claims submitted directly to MassHealth for audio-only telehealth services to dually eligible members as described above.

Billing Instructions for 837P Transactions

For claims meeting the above criteria, complete the other payer loops in the 837P transaction as described in the following table.

Loop	Segment	Value
2320	SBR09 (Claim Filing Indicator)	MB
2320	AMT01 (Total Noncovered Amount Qualifier)	A8
2320	AMT02 (Total Noncovered Amount)	The total noncovered amount must equal the total billed amount.
2330B	NM109 (Other Payer Name)	0085000

Please note: Providers must follow the HIPAA 837P Implementation Guide and the MassHealth 837P Companion Guide instructions when submitting claims to MassHealth.

Billing Instructions for Direct Data Entry (DDE)

For claims meeting the above criteria, complete the coordination of benefits (COB) panel in the Provider Online Service Center (POSC) direct data entry (DDE) claim panels.

On the Coordination of Benefits tab, click New Item and complete all applicable fields including the fields described in the following table.

Coordination of Benefits Panel	
Field Name	**Instructions**
Carrier Code	Enter 0085000.
Carrier Name	Enter Medicare B.
Remittance Date	Do not enter a remittance date.
Payer Claim Number	Enter 99.
Payer Responsibility	Select the appropriate code from the drop-down list.
COB Payer Paid Amount	Do not enter a COB payer paid amount.
Total Noncovered Amount	Enter the total billed amount. The total noncovered amount must equal the total billed amount.
Remaining Patient Liability	Do not enter any values.
Claim Filing Indicator	Enter MB.

Please Note: Providers should not complete the fields in the List of COB Reasons panel or the List of COB line items panel when billing for these Medicare non-covered services.

Payment for Specimen Collection

To facilitate the testing of MassHealth members suspected of having COVID-19, including at rapid-testing sites operating in accordance with MassHealth and Department of Public Health rules and regulations, and in recognition of the unique costs incurred by providers collecting specimens from those members, MassHealth is implementing additional flexibilities to allow providers to separately bill and receive payment for COVID-19 specimen collection services, in addition to the other billable services provided during the encounter.

More specifically, and notwithstanding any requirement to the contrary, including 130 CMR 401.411(A), 130 CMR 405.433(B), 130 CMR 410.455(A), 130 CMR 421.433(B), and 130 CMR 433.439(A), MassHealth will permit providers enrolled in the MassHealth physician, acute outpatient hospital, community health center, family planning agency, or clinical laboratory programs to bill MassHealth separately for either or both 1) the collection of specimens for the purpose of clinical laboratory testing for COVID-19, and 2) the laboratory analysis of such specimens.

Additionally, notwithstanding any requirement to the contrary, providers rendering either or both of these COVID-19-related laboratory services during the course of or in connection with a payable medical visit, whether such visit occurs in person or via telehealth, may bill MassHealth for the provision of those services separately from the medical visit. For example, a provider rendering COVID-19-related specimen collection and laboratory analysis services during the course of a payable medical visit may bill MassHealth for (1) the COVID-19 specimen collection, (2) the laboratory analysis of that specimen, and (3) the medical visit.

These flexibilities apply to dates of service beginning March 12, 2020, for the duration of the state of emergency declared by Executive Order No. 591. Providers billing MassHealth for specimen collection services rendered pursuant to this policy must use HCPCS codes G2023 or G2024.

MassHealth has issued, or will issue, transmittal letters that add these codes to the relevant provider manuals. Providers billing MassHealth for COVID-19 specimen collection pursuant to this flexibility must comply in all respects with all other applicable laws, regulations, subregulatory guidance, and contracts.

A community health center provider that partners with an EOHHS-approved laboratory that is not a MassHealth provider to deliver COVID-19 related laboratory services, in accordance with a forthcoming MassHealth Community Health Center Provider Bulletin, may bill MassHealth for the COVID-19 specimen collection and the laboratory analysis, whether such services are conducted directly by the community health center or by its EOHHS-approved laboratory partner. Community health centers may bill for a medical visit provided in addition to COVID-19 laboratory services they provide, but COVID-19 specimen collection or laboratory testing services alone do not amount to a medical visit. The community health center may not bill for an individual medical visit or an Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) visit when a member is being seen only for laboratory services.

COVID-19 Remote Patient Monitoring

In order to divert unnecessary emergency and hospital utilization during the COVID-19 emergency, MassHealth is adding to the MassHealth Physician, Community Health Center, and Acute Outpatient Hospital program manuals coverage of a code for COVID-19 remote patient monitoring (COVID-19 RPM) bundled services to facilitate home- or residence-based monitoring of members with confirmed or suspected COVID-19 who do not require emergency department or hospital level of care but require continued close monitoring.

The COVID-19 RPM bundle includes all medically necessary evaluation and management (E&M) services required to facilitate seven days of close, in-home, monitoring of members with confirmed or suspected COVID-19, as further described below. Providers rendering COVID-19 RPM bundled services must comply in all respects with this bulletin and other applicable laws, regulations, subregulatory guidance, and contracts.

The following provider types may render COVID-19 RPM bundled services:

- Physician (provider type (PT 01);
- Community Health Centers (PT 20);
- Acute Outpatient Hospitals (PT 80);
- Hospital Licensed Health Centers (PT 81); and
- Group Practices (PT 97).

Eligible providers may render COVID-19 RPM bundled services to MassHealth members meeting either of the following clinical eligibility criteria:

1. Members with **confirmed or suspected COVID-19** who present to an appropriate clinical professional (either in-person or by telehealth), and in that clinical professional's judgment, the person is stable enough to isolate at home, but requires close monitoring for deterioration and need for a higher level of care; or
2. Members who have been hospitalized due to **confirmed or suspected COVID-19,** who in the judgment of an appropriate clinical professional, are stable enough to be discharged to home or another community-based setting, but require continued close monitoring for deterioration and need for a higher level of care

Providers rendering COVID-19 RPM bundled services must, at a minimum:

- Ensure that a physician, midlevel professional (such as a physician assistant or certified nurse practitioner), or paraprofessional (such as a medical assistant or a licensed practical nurse), checks in with the member at least once per day to assess symptoms and record home bio-monitoring data (e.g., oxygen saturation, temperature). Eligible providers may perform these check-ins via telehealth in accordance with All Provider Bulletins 289 and 291. Providers unable to contact a member to whom they are rendering COVID-19 RPM bundled services must make their best effort to contact that member and exercise reasonable judgment to determine whether in-person follow-up is possible or necessary. Providers must document such outreach and attempts to contact members throughout the seven-day monitoring period.
- On at least a daily basis, convene a multidisciplinary team to review the status of members receiving COVID-19 RPM bundled services and coordinate care related to all needs identified through the provider's monitoring of the member, as necessary. At a minimum, the multidisciplinary team must include a physician, as well as any other provider staff who are involved in care for that member, including those who are conducting outreach to the member that day. The multidisciplinary case review may occur in-person or through the use of remote technology, provided that all relevant members of the clinical care team as described above are participating in a live discussion to address identified member needs and coordinate care as necessary. Care coordination includes any coordination of services needed to address the monitored member's suspected or confirmed COVID-19. This may include, but is not limited to, facilitating an array of medically necessary services, such as hospital admission, the involvement of social workers, or medication refills.
- Provide physician oversight as needed. MassHealth expects that, as part of the COVID-19 RPM bundled services, the physician will perform at least one evaluation and management visit (either in-person or via telehealth in accordance with All Provider Bulletins 289 and 291) over the course of the seven-day monitoring period, if consistent with patient need and medically necessity.
- Ensure that each member receiving COVID-19 RPM bundled services has access to a thermometer and a pulse oximeter upon the commencement of COVID-19 RPM bundled services. If the member lacks access to either or both pieces of equipment, the provider must provide the member such equipment. The provider may not bill MassHealth or the member for this equipment.

Billing Specifications

- Providers will determine that a member is clinically eligible for COVID-19 RPM bundled services during the course of a hospitalization or a separately billable provider evaluation and management visit (either in-person or by telehealth in accordance with All Provider Bulletins 289 and 291).
- Providers initiate the provision of COVID-19 RPM bundled services by billing the code 99423 with modifier U9 on the first day the provider renders COVID-19 RPM bundled services. Providers may not bill this code again during the next seven days (including the date on which the provider billed 99423-U9). MassHealth will issue transmittal letters that add coverage of this code in the relevant provider manuals.
- The COVID-19 RPM bundle is intended to cover all COVID-19-related E&M services rendered for a period of up to seven days. MassHealth will not prorate this payment if the member ultimately requires fewer than seven days of COVID-19-related E&M services. Providers who

determine that a member receiving COVID-19 RPM bundled services no longer requires those services must document this fact in the member's medical record, including the reason for that determination (e.g., improvements in the patient's condition rendering monitoring services medically unnecessary, or the member's transition to a different level of care).

- A provider may furnish and bill for a subsequent COVID-19 bundle after the member's initial seven-day service period concludes only if a physician determines, following an E&M visit with the member (whether conducted in-person or via telehealth), that the continuation of reinitiation of RPM services for the member is clinically appropriate and medically necessary.
- Pursuant to Administrative Bulletin 20-40, MassHealth will pay providers rendering COVID-19 RPM bundled services at the bundled payment rate set forth in that administrative bulletin for all bundled services rendered over the course of the seven-day service period.
- Except for COVID-19 related E&M services included in the COVID-19 RPM bundle, as well as the provision of the associated durable medical equipment (i.e., a thermometer and a pulse oximeter), providers may bill separately for other medically necessary services for members being remotely monitored during the seven-day period, such as pharmacy, behavioral health, or substance use disorder services, as long as the additional services are not duplicative of the COVID-19-related E&M services provided as part of the COVID-19 RPM bundle.
  - Pursuant to 130 CMR 450.235, MassHealth does not pay for duplicative services. In the case of COVID-19 RPM bundled services, duplicative services may include, but are not limited to, any other E&M service, telehealth encounter, or home visit related to COVID-19.
- Eligible providers may bill MassHealth a facility fee for the COVID-19 RPM bundle if such a fee is permitted under such provider's governing regulations or contracts. Eligible providers may bill such a facility fee only once during the seven-day monitoring period. Eligible providers must bill such a facility fee by using:
  - Procedure code 99423 with modifier U9
  - U07.1 as the principal diagnosis code
  - Observation revenue code 762
- Providers may render COVID-19 RPM bundled services to all MassHealth members, regardless of their coverage type. Additionally, the Health Safety Net will pay for COVID-19 RPM bundled services provided by acute hospitals and community health centers.

Additional Notes on Durable Medical Equipment for RPM

- To facilitate remote patient monitoring, providers billing the COVID-19 RPM bundle must provide members receiving those services a thermometer and a pulse oximeter on the first day of the service period, or ensure that the member has access to these pieces of equipment (i.e., if the member currently has access to adequate equipment, the provider must document this fact, but need not issue additional equipment to the member unless the member loses access to the preexisting thermometer and/or pulse oximeter). MassHealth will not provide separate reimbursement for the provision of this equipment. Providers are responsible for obtaining these pieces of equipment.
- If additional medically necessary equipment or supplies beyond a thermometer and pulse oximeter are indicated for a member, such as a blood pressure cuff or blood glucose monitor, a provider may order such additional supplies separately as needed through existing MassHealth DME benefit channels.

- Upon the conclusion of the service period, providers may allow members to keep any thermometer and/or pulse oximeter furnished to the member for use as part of the COVID-19 RPM bundle. Alternatively, providers may collect this used equipment at the conclusion of the monitoring service and sterilize for reuse.

Informational Edits Extended past June 1, 2020

As explained in Transmittal Letters PHY-157, AOH-45, IDTF-20, and CHC-113, effective March 1, 2020, MassHealth began requiring prior authorization (PA) for certain advanced imaging, non-obstetric ultrasound, polysomnography, and cardiology services (collectively, the Services Requiring PA). To facilitate and ease the implementation of this requirement, on March 1, 2020, MassHealth implemented an informational edit that will not deny claims for Services Requiring PA for lack of PA, but instead will inform providers of the PA requirement for those services and codes.

Although MassHealth intended to discontinue this informational edit on May 31, 2020, and implement hard denials of claims for Services Requiring PA for lack of PA on June 1, 2020, due to the COVID-19 emergency, MassHealth will extend this informational edit for the duration of the state of emergency declared via Executive Order No. 591. In other words, MassHealth will not deny claims for Services Requiring PA for lack of PA beginning on June 1, 2020. MassHealth will publish a subsequent bulletin prior to implementing denials of claims for Services Requiring PA for lack of PA.

Coverage of Preventive Visits via Telehealth

MassHealth recognizes the challenges being faced by primary care providers during the COVID-19 emergency, especially as it relates to completing important preventive visits for children and adults. During the COVID-19 emergency, MassHealth allows, but does not require, providers to render preventive visits via telehealth when clinically appropriate. As outlined in All Provider Bulletins 289 and 291, MassHealth will pay claims for such services, as long as the claim identifies the Place of Service as "02". MassHealth encourages providers to adhere to recommendations from the American Academy of Pediatrics on delivery of preventive services during the COVID-19 emergency, including the recommendation to prioritize in-person newborn care and well visits and immunization of infants and young children (through 24 months of age) whenever possible.

For those preventive visits that are completed via telehealth, MassHealth is aware that there may be medically necessary components of those visits that cannot be completed via telehealth modalities. MassHealth recommends that providers complete the unperformed components of those visits as soon as possible, whether before or after the emergency concludes.

Therefore, MassHealth anticipates that some providers will need to conduct in-person, follow-up visits to complete those medically necessary, yet unperformed components of a preventive visit conducted via telehealth. MassHealth is implementing the following policy to address this need:

- For a preventive visit conducted via telehealth, providers may bill:
  - An appropriate preventive visit code plus "02" for place of service;
  - Any additional codes applicable to the service provided (e.g., developmental screening, health risk assessment, behavioral/emotional assessment); and
  - Separately for vaccines administered on the same date as the telehealth visit, as the vaccine administration and the telehealth visit do not occur in the same location. Providers may not use place of service code "02" when submitting claims for such same-day vaccine administrations.

- For an in-person follow-up visit to complete medically necessary components of the preventive visit, not performed on the same day as the preventive visit, providers may bill:
  - A single E&M visit at level 1, 2, or 3 (appropriate to complexity of visit); and
  - Any additional codes applicable to the service provided (e.g., laboratory, hearing/vision screening).

Providers must document all required components of all visits, including preventive visits. Documentation of preventive visits conducted via telehealth must indicate that the visit was completed via telehealth due to the COVID-19 emergency, note any limitations of the visit, and include a plan to follow up any medically necessary components deferred due to those limitations.

MassHealth will apply this policy to all dates of service beginning on March 12, 2020.

Additional Information

For the latest MA-specific information, visit https://www.mass.gov/resource/information-on-the-outbreak-of-coronavirus-disease-2019-covid-19.

The latest Centers for Disease Control and Prevention (CDC) guidance for healthcare professionals is available at https://www.cdc.gov/coronavirus/2019-ncov/hcp/index.html.

MassHealth Website

This bulletin is available on the MassHealth Provider Bulletins web page.

To sign up to receive email alerts when MassHealth issues new bulletins and transmittal letters, send a blank email to join-masshealth-provider-pubs@listserv.state.ma.us. No text in the body or subject line is needed.

Questions

If you have any questions about the information in this bulletin, please contact MassHealth as applicable for your provider type.

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